103D CONGRESS
1ST SESSION

S. 1282

To increase the number of primary health care providers, help assure access to health care in rural and other underserved areas, and increase retention rates among primary health care providers in rural and underserved areas.

IN THE SENATE OF THE UNITED STATES

JULY 23 (legislative day, JUNE 30), 1993

Mr. BINGAMAN introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To increase the number of primary health care providers, help assure access to health care in rural and other underserved areas, and increase retention rates among primary health care providers in rural and underserved areas.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Graduate Reform Opportunities and Work Force Training in Health Act'' (GROWTH).

SEC. 2. FINDINGS.

Congress finds that—

(1) of the approximately 600,000 practicing physicians in the United States, only one-third are in primary health care and, of recent United States medical school graduates, only one-sixth are choosing primary health care careers;

(2) every year, more United States medical school graduates enter specialty fields, turning away from the practice of primary health care;

(3) although the Nation's physician-to-population ratio has increased significantly in recent years and the total United States physician supply has doubled over the past 3 decades, rural areas throughout the country face growing access-to-care problems;

(4) the number of physicians entering rural practice is declining and many rural areas are experiencing shortages of primary health care providers;

(5) because almost 20 percent of physicians practicing in rural counties are over the age of 65, physician shortages in such counties are expected to become worse over the next few years as these providers retire;

(6) one-quarter of the United States population lives in rural areas;

(7) rural communities have unique characteristics and special needs which challenge the health care delivery system;

(8) in addition to training too few primary health care providers and providers willing to practice in rural areas, the United States trains too few minority providers;

(9) the growing number of highly compensated specialists contributes to the difficulty the United States faces in containing health care costs and increasing access to basic health care services;

(10) there is no national plan or set of appropriate incentives in medical education financing systems to achieve the desired physician specialty mix, racial and ethnic composition, and geographic distribution; and

(11) it is in the best interest of the United States to establish such a national plan and such incentives in Federal medical education financing systems.

SEC. 3. HEALTH WORK FORCE INTERAGENCY TASK FORCE.

Part F of title VII of the Public Health Service Act (42 U.S.C. 295 et seq.) is amended by adding at the end the following new section:

''SEC. 783. HEALTH WORK FORCE INTERAGENCY TASK FORCE.

''(a) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this section, the Secretary shall establish a Health Work Force Interagency Task Force. The Task Force shall be composed of representatives of Federal agencies and departments that have responsibility for the training, monitoring, funding, or supporting of health care professions.

''(b) CO-CHAIRPERSONS.—The Assistant Secretary for Health and the Assistant Secretary for Post-secondary Education shall serve as the co-chairpersons of the Task Force established under subsection (a).

''(c) FUNCTIONS AND ACTIVITIES.—The Task Force established under subsection (a) shall—

''(1) review and coordinate all health work force development and training efforts supported by the Federal Government;

''(2) make recommendations to the Secretary of Health and Human Services and the Secretary of Education for coordinating Federal vocational education policy with national health work force needs and goals;

''(3) develop standards for programs on vocational education in the health care professions and procedures for program accountability; and

''(4) carry out any other activity determined appropriate by the Secretary of Health and Human Services and the Secretary of Education.

''(d) REPORT.—Not later than 13 months after the establishment of the Task Force under subsection (a), and annually thereafter, the Task Force shall prepare and submit to the appropriate committees of Congress a report concerning the types and funding levels of vocational education in the health care professions for which the Federal Government provides support and detailing the activities of the Task Force over the preceding 12-month period.''.

SEC. 4. PROGRAMS FOR PRIMARY HEALTH CARE IN RURAL AREAS.

Section 778(b)(1) of the Public Health Service Act (42 U.S.C. 294p(b)(1)) is amended—

(1) in subparagraph (D), by striking ''and'' at the end;

(2) in subparagraph (E), by striking the period and inserting a semicolon; and

(3) by adding at the end the following new subparagraphs:

''(F) establish training programs in medical schools that recruit students from rural underserved areas who have demonstrated a com-

mitment to careers in primary care medicine and service in rural underserved areas;

''(G) give preference under the National Health Service Corps and other Federal scholarship programs to candidates from and likely to practice in rural underserved areas;

''(H) develop training programs for health care practitioners that provide curricula and faculty role models appropriate to a rural health setting;

''(I) develop training programs for underrepresented minorities in rural health settings;

''(J) develop demonstration programs for infrastructure development in rural health settings, including the development of state-of-the-art telecommunications and network systems that link health care providers in rural areas with other rural and urban health care providers and academic health centers;

''(K) establish State and regional locum tenens programs in rural health settings so that substitute health care providers are available when permanent staff is absent from the health care setting; and

''(L) implement programs using inter-disciplinary team approaches to health care training and practice.''.

SEC. 5. TERTIARY CARE CENTER TRAINING FOR NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS AND PHYSICIAN ASSISTANTS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293j et seq.) is amended by adding at the end the following new section:

''SEC. 753. TERTIARY CARE CENTER TRAINING FOR NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS AND PHYSICIAN ASSISTANTS.

''The Secretary shall develop training programs for nurse practitioners, clinical nurse specialists and physician assistants designed to prepare trainees in such programs to staff tertiary care centers in a manner that addresses the current and projected needs of such centers.''.

SEC. 6. LIFE-TIME LEARNING.

Subtitle C of title VII of the Public Health Service Act (42 U.S.C. 293j et seq.), as amended by section 5, is further amended by adding at the end the following new section:

''SEC. 754. LIFE-TIME LEARNING DEMONSTRATION PROGRAM.

''(a) IN GENERAL.—The Secretary, through grants, contracts or cooperative agreements, shall support the establishment of demonstration projects in 10 States concerning the retraining of certain physicians.

''(b) APPLICATIONS.—To be eligible to receive assistance under subsection (a), an entity shall—

''(1) be a State or other public or nonprofit private entity; and

''(2) prepare and submit to the Secretary an application, at such time, in such manner and containing such information as the Secretary may require.

''(c) USE.—An entity receiving assistance under subsection (a) shall conduct a program to—

''(1) evaluate the cost-effectiveness of retraining physicians who are trained and practicing in oversubscribed specialties to—

''(A) serve in medically underserved areas in or outside of the United States; or

''(B) retrain for practice in primary health care; and

''(2) conduct outcomes research targeted at improving the scientific basis of medical practice.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $20,000,000 for each of the fiscal years 1994 through 1998.''.

SEC. 7. HEALTH WORK FORCE NEEDS STUDY.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with a public or nonprofit private entity to conduct a study for the purpose of assessing current and projected health work force needs in order to promote cost-effective, quality patient care.

(b) NATIONAL ACADEMY OF SCIENCES.—The Secretary shall request the National Academy of Sciences to enter into the contract described in subsection (a). If the Institute declines to conduct the study under such contract, the Secretary of Health and Human Services shall carry out such subsection through another public or nonprofit private entity.

(c) REPORT.—The Secretary shall ensure that, not later than October 1, 1995, the study required in subsection (a) is completed and a report describing the findings made as a result of such study is submitted to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate.''.

SEC. 8. PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (1), by striking ''hospitals'' each place it appears and inserting ''GME consortia'';

(2) by amending paragraph (2) to read as follows:

''(2) DETERMINATION OF AVERAGE PER RESIDENT AMOUNT.—The Secretary shall determine for all GME consortia with approved medical residency training programs, an average per resident amount for cost reporting periods beginning on or after July 1, 1995 as follows:

''(A) BASE AMOUNT.—The Secretary shall determine the national mean of all hospital specific FTE resident amounts for cost reporting periods beginning on or after July 1, 1994, and ending on or before June 30, 1995, under this subsection as in effect on the day before the date of the enactment of the Graduate Reform Opportunities and Work Force Training in Health Act.

''(B) INFLATION ADJUSTMENT TO BASE AMOUNT.—

''(i) AMOUNT FOR THE FIRST REPORTING PERIOD.—For the first cost reporting period of the GME consortium beginning on or after July 1, 1995, the average per resident amount for the GME consortium is the amount determined under subparagraph (A) updated by the estimated percentage increase in the Consumer Price Index during the 12-month period described in subparagraph (A).

''(ii) SUBSEQUENT COST REPORTING PERIODS.—For each subsequent cost reporting period, the per average resident amount for the GME consortium is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the Consumer Price Index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this clause in the

projected percentage change in the Consumer Price Index.''.

(3) by amending paragraph (3) to read as follows:

''(3) GME CONSORTIUM PAYMENT AMOUNT PER RESIDENT.—

''(A) IN GENERAL.—The payment amount, for a GME consortium cost reporting period beginning on and after July 1, 1995, is equal to the product of—

''(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

''(ii) the GME consortium's medicare patient load (as defined in subparagraph (C)) for that period.

''(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term 'aggregate approved amount' means, for a GME consortium cost reporting period, the product of—

''(i) the average per resident amount determined under paragraph (2) for that period, and

''(ii) the weighted average number of full-time-equivalent residents (as deter-

mined under paragraph (4)) in the GME consortium's approved medical residency training programs in that period.

''(C) MEDICARE PATIENT LOAD.—As used in subparagraph (A), the term 'medicare patient load' means with respect to a GME consortium's cost reporting period the sum of—

''(i) the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which is attributable to patients with respect to whom payment may be made under part A; and

''(ii) in the case of a member entity of a GME consortium that does not furnish inpatient services but does furnish services for which payment may be made under part B, the fraction of the total number of all services provided by such member during the period attributable to services for which payment may be made under part B.'';

(4) in paragraph (4)—

(A) by amending subparagraph (A) to read as follows:

''(A) IN GENERAL.—

''(i) AGGREGATE NUMBER OF FIRST-YEAR RESIDENTS.—For the 12 month period beginning on July 1, 1995, and for each succeeding 12 month period, the aggregate number of first-year residency positions for which payment may be made under this subsection shall be equal to 110 percent of the total number of graduates of United States medical schools in calendar year 1994.''.

''(ii) PROPORTION OF SPECIALTY POSITIONS.—The total number of first-year specialty residency positions for which payment under this section may be made shall be equal to—

''(I) 65 percent of the aggregate number of residency positions determined under clause (i) for the period July 1, 1995, through June 30, 1996,

''(II) 60 percent of the aggregate number of residency positions determined under clause (i) for the period July 1, 1996, through June 30, 1997,

''(III) 50 percent of the aggregate number of residency positions determined under clause (i) for the 12 month period

beginning July 1, 1997, and for each succeeding 12 month period.

''(iii) ALLOCATION TO GME CONSORTIA.—

''(I) IN GENERAL.—For the 12 month period beginning on July 1, 1995, and for each succeeding 12 month period, the Secretary shall allocate the first year residency positions permitted under clause (i) to GME consortia after considering the recommendations of the National Health Care Work Force Board established in section 9 of the Graduate Reform Opportunities and Work Force Training in Health Act. Each residency position allocated to a GME consortium under this subclause shall remain allocated to such consortium until the individual who fills such position completes such individual's residency training.

''(II) NOTICE.—The Secretary shall notify each GME consortium of such consortium's allocation of first-year residency positions at least 1 year before the beginning of the residency year for which such allocation applies.

''(III) FUNDING ELIGIBILITY CRITERIA.—The Secretary shall provide that a GME consortium receiving funds under this subsection maintains an approved medical residency program.''.

(B) by amending subparagraph (B) to read as follows—

''(B) RULES FOR DETERMINING FULL-TIME EQUIVALENT RESIDENTS.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program. Such rules shall take into account individuals who serve United States residents for only a portion of a period with a GME consortium or simultaneously with more than 1 GME consortium.''; and

(C) by amending subparagraph (C) to read as follows:

''(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved medical residency training program—

''(i) for a resident who is in the resident's initial residency period, the weighting factor is 0.80 (1.50, in the case of a resident who is in a residency in a rural area as defined in section 1886(d)(2)(D)), and

''(ii) for a resident who is not in the resident's initial residency period, the weighting factor is 0.50 (1.50, in the case of a resident who is in a residency in a rural area as defined in section 1886(d)(2)(D)).''; and

(D) in subparagraph (E), by striking ''hospital'' and inserting ''GME consortium''; and

(7) in paragraph (5)—

(A) in subparagraph (A), by inserting ''offered by a consortium'' after ''postgraduate medical training program''; and

(B) by adding at the end the following new subparagraphs:

''(I) GME CONSORTIUM.—

''(i) IN GENERAL.—The term 'GME consortium' means a group composed of at least 1 medical school, 1 teaching hospital, and 1 community-based ambulatory train-

ing site (including a physician's office, a community health center, or a rural health clinic) that is organized and overseen by a member medical school.

''(ii) COST REPORTING PERIOD.—For purposes of this subsection, a consortium's cost reporting period shall be the cost reporting period of a member hospital, as determined by the Secretary.

''(iii) REPORTS.—Each GME consortium shall submit an annual report to the National Health Care Work Force Board describing—

''(I) the organization of the GME consortium's approved medical residency training programs, and

''(II) the location and professional activities of each individual that completed the GME consortium's approved medical residency training program in the prior 3 years.

''(J) PRIMARY CARE RESIDENCY.—The term 'primary care residency' means a residency in family medicine, general internal medicine, or general pediatric medicine.

''(K) SPECIALTY RESIDENCY.—The term 'specialty residency' means a residency that is not a primary care residency.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall be effective for cost reporting periods beginning on or after July 1, 1995.

SEC. 9. NATIONAL HEALTH CARE WORK FORCE BOARD.

(a) ESTABLISHMENT.—There is established a Board to be known as the National Health Care Work Force Board (hereafter in this section referred to as the ''Board'').

(1) MEMBERSHIP.—

(A) COMPOSITION.—The Board shall be composed of—

(i) 11 voting members to be appointed by the President no later than January 1, 1994, and

(ii) 3 non-voting members consisting of—

(I) the Secretary of Health and Human Services (hereafter in this section referred to as the ''Secretary''),

(II) the Director of the Health Care Financing Administration, and

(III) the Director of the Health Resources and Services Administration,

or the designees of such individuals.

(B) QUALIFICATIONS.—The members of the Board appointed under subparagraph (A)(i) shall include individuals who—

(i) have national recognition for expertise in the health professions, hospital and community-based care, biomedicine, health services and health economics research, licensing, accreditation, certification, and related fields, and

(ii) are and represent consumers of health services.

(C) PROHIBITION.—A member of the Board appointed under subparagraph (A)(i) may not be an employee or officer of the Federal Government.

(2) PERIOD OF APPOINTMENT; VACANCIES.—

(A) TERMS.—The members of the Board appointed under paragraph (1)(A)(i) shall be appointed to serve for terms of 4 years, except that the terms of the members first appointed

may be staggered to ensure that the terms of no more than 3 members expire in any 1 year.

(B) VACANCIES.—

(i) IN GENERAL.—The President shall make an appointment to fill a vacancy on the Board not later than 90 days from the date that the vacancy occurred.

(ii) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(iii) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

(3) CHAIRPERSON.—The Board shall annually select a Chairperson from among its members.

(4) MEETINGS.—

(A) IN GENERAL.—The Board shall meet not less than twice a year at the call of the Chairperson, or on a written request of one-third of the members of the Board.

(B) INITIAL MEETING.—The Board shall hold its first meeting not later than March 31, 1994.

(C) QUORUM.—A majority of the members of the Board shall constitute a quorum, but a lesser number of members may hold hearings.

(b) FUNCTIONS.—

(1) ALLOCATION RECOMMENDATION.—

(A) INFORMATION COLLECTION AND RECEIPT OF REQUESTS.—The Board shall—

(i) seek the recommendations of private accrediting bodies concerning the ranking of medical residency programs according to program quality;

(ii) collect data from the Department of Health and Human Services and State health departments on national, State, and regional health work force needs; and

(iii) solicit and receive requests from GME consortia (as defined in section 1886(h)(5)(I) of the Social Security Act) concerning the number and types of residency positions for which graduate medical education funds under section 1886(h) of the Social Security Act are sought;

(B) RECOMMENDATIONS.—The Board shall develop and submit to the Secretary on an annual basis recommendations on the number

and types of first-year residency training positions for which each GME consortium should receive graduate medical education funds under section 1886(h) of the Social Security Act based on quality of the medical residency program operated by the GME consortium and evaluation of national, State, and regional needs.

(2) STUDY.—

(A) IN GENERAL.—The Board shall conduct a thorough study of—

(i) current and projected health care work force needs and the extent to which the work force represents the areas and populations to be served;

(ii) State licensing, accreditation and certification policies, reimbursement practices, and medical liability practices that may discourage health care providers from entering or practicing primary care medicine or create disincentives to the practice of medicine in rural areas; and

(iii) the need to limit non-federally supported specialty residency positions.

(B) RECOMMENDATIONS.—The Board shall develop recommendations on each of the matters studied under subparagraph (A).

(C) REPORT.—The Board shall submit a report to the Congress which shall contain a detailed statement of the findings and conclusions of the Board, together with its recommendations for such legislation and administrative actions as it considers appropriate—

(i) not later than September 30, 1998, for the matter studied in subparagraph (A)(iii), and

(ii) not later than September 30, 1996, for the matter studied in clauses (i) and (ii) of subparagraph (A).

(3) LEGISLATIVE PROPOSALS.—

(A) NUMBER OF RESIDENTS.—

(i) INITIAL PROPOSAL.—Not later than 3 years after the date of the enactment of this Act, the Board shall develop and submit to Congress a legislative proposal that adjusts the aggregate number of federally-funded residency positions under section 1886(h)(4)(A)(i) of the Social Security Act for the 3-year period beginning

on July 1, 1998, and ending on June 30, 2001, based on the Board's evaluation of national, State, and regional needs.

(ii) SUBSEQUENT PROPOSALS.—Not later than 3 years after the date the last legislative proposal was submitted under this subparagraph, the Board shall develop and submit to Congress a legislative proposal described in clause (i) for the following 3-year period.

(B) PROPORTION OF FUNDED SPECIALTY RESIDENCIES.—

(i) INITIAL PROPOSAL.—Not later than 3 years after the date of the enactment of this Act, the Board shall develop and submit to Congress a legislative proposal that adjusts the proportion of specialty residency positions under section 1886(h)(4)(A)(ii) of the Social Security Act for the 3-year period beginning on July 1, 1998, and ending on June 30, 2001, based on the Board's evaluation of national, State, and regional needs.

(ii) SUBSEQUENT PROPOSALS.—Not later than 3 years after the date the last

legislative proposal was submitted under this subparagraph, the Board shall develop and submit to Congress a legislative proposal described in clause (i) for the following 3-year period.

(C) APPROVAL RESOLUTION.—The legislative proposals described in subparagraphs (A) and (B) shall be considered by Congress under the procedures for consideration of an ''approval resolution'' as described in subsection (c).

(c) CONGRESSIONAL CONSIDERATION OF APPROVAL RESOLUTION.—

(1) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This paragraph is enacted by Congress—

(A) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of approval resolutions described in paragraph (2), and supersedes other rules only to the extent that such rules are inconsistent therewith; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

(2) TERMS OF THE RESOLUTION.—For purposes of paragraph (1), the term ''approval resolution'' means only a joint resolution of the 2 Houses of Congress, providing in—

(A) the matter after the resolving clause of which is as follows: ''That Congress approves the legislative proposal of the National Health Care Work Force Board as submitted by the Board on _____'', the blank space being filled in with the appropriate date; and

(B) the title of which is as follows: ''Joint Resolution approving the legislative proposal of the National Health Care Work Force Board.''.

(3) INTRODUCTION AND REFERRAL.—On the day on which the legislative proposal of the Commission is transmitted to the House of Representatives and the Senate, an approval resolution with respect to such proposal shall be introduced (by request) in

the House of Representatives by the majority leader of the House, for himself and the minority leader of the House, or by Members of the House designated by the majority leader of the House, for himself and the minority leader of the House, or by Members of the House designated by the majority leader and minority leader of the House; and shall be introduced (by request) in the Senate by the majority leader of the Senate, for himself and the minority leader of the Senate, or by Members of the Senate designated by the majority leader and minority leader of the Senate. If either House is not in session on the day on which such proposal is transmitted, the approval resolution with respect to such proposal shall be introduced in the House, as provided in the preceding sentence, on the first day thereafter on which the House is in session. The approval resolution introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(4) AMENDMENTS PROHIBITED.—No amendment to an approval resolution shall be in order in either the House of Representatives or the Senate and no motion to suspend the application of this paragraph shall be in order in either House, nor

shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this paragraph by unanimous consent.

(5) PERIOD FOR COMMITTEE AND FLOOR CONSIDERATION.—

(A) IN GENERAL.—Except as provided in clause (ii), if the committee or committees of either House to which an approval resolution has been referred have not reported it at the close of the 45th day after its introduction, such committee or committees shall be automatically discharged from further consideration of the approval resolution and it shall be placed on the appropriation calendar. A vote on final passage of the approval resolution shall be taken in each House on or before the close of the 45th day after the approval resolution is reported by the committees or committee of that House to which it was referred, or after such committee or committees have been discharged from further consideration of the approval resolution. If prior to the passage by 1 House of an approval resolution of that House, that House receives the same approval resolution from the other House then—

(i) the procedure in that House shall be the same as if no approval resolution had been received from the other House; but

(ii) the vote on final passage shall be on the approval resolution of the other House.

(B) COMPUTATION OF DAYS.—For purposes of clause (i), in computing a number of days in either House, there shall be excluded any day on which the House is not in session.

(6) FLOOR CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(A) MOTION TO PROCEED.—A motion in the House of Representatives to proceed to the consideration of an approval resolution shall be highly privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(B) DEBATE.—Debate in the House of Representatives on an approval resolution shall be limited to not more than 20 hours, which shall be divided equally between those favoring

and those opposing the bill or resolution. A motion further to limit debate shall not be debatable. It shall not be in order to move to recommit an approval resolution or to move to reconsider the vote by which an approval resolution is agreed to or disagreed to.

(C) MOTION TO POSTPONE.—Motions to postpone, made in the House of Representatives with respect to the consideration of an approval resolution, and motions to proceed to the consideration of other business, shall be decided without debate.

(D) APPEALS.—All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to an approval resolution shall be decided without debate.

(E) GENERAL RULES APPLY.—Except to the extent specifically provided in the preceding provisions of this subsection, consideration of an approval resolution shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions in similar circumstances.

(7) FLOOR CONSIDERATION IN THE SENATE.—

(A) MOTION TO PROCEED.—A motion in the Senate to proceed to the consideration of an approval resolution shall be privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(B) GENERAL DEBATE.—Debate in the Senate on an approval resolution, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the majority leader and the minority leader or their designees.

(C) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with an approval resolution shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the approval resolution, except that in the event the manager of the approval resolution is in favor of any such motion or appeal, the time in opposition thereto, shall be controlled by the minority leader or his designee. Such leaders, or either of

them, may, from time under their control on the passage of an approval resolution, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(D) OTHER MOTIONS.—A motion in the Senate to further limit debate is not debatable. A motion to recommit an approval resolution is not in order.

(8) POINT OF ORDER REQUIRING SUPERMAJORITY FOR MODIFICATIONS TO PROPOSAL ONCE APPROVED.—

(A) IN GENERAL.—It shall not be in order in the House of Representatives or the Senate to consider any amendment to the provisions of the Graduate Reform Opportunities and Work Force Training in Health Act except as provided in subparagraph (B).

(B) WAIVER.—The point of order described in subparagraph (A) may be waived or suspended in the House of Representatives or the Senate only, by the affirmative vote of three-fifths of the Members duly chosen and sworn.

(d) RESUBMISSIONS.—If a legislative proposal of the Board submitted under subparagraph (A) or (B) of sub-

section (b)(3) is not approved by Congress within 90 days of the submission of such proposal to Congress, or is approved by Congress and vetoed by the President (and such veto is not overridden by the Congress), the Board shall submit a new legislative proposal not later than 90 days after Congress failed to approve the proposal or the President failed to override the President's veto, and such new legislative proposal shall be subject to congressional consideration as provided in subsection (c).

(e) POWERS OF THE BOARD.—

(1) HEARINGS.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out the purposes of this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Board may secure directly from any Federal department or agency such information as the Board considers necessary to carry out the provisions of this section. Upon request of the Chairperson of the Board, the head of such department or agency shall furnish such information to the Board.

(3) POSTAL SERVICES.—The Board may use the United States mails in the same manner and

under the same conditions as other departments and agencies of the Federal Government.

(4) GIFTS.—The Board may accept, use, and dispose of gifts or donations of services or property.

(g) BOARD PERSONNEL MATTERS.—

(1) COMPENSATION OF MEMBERS.—Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. All members of the Board who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES.—The members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

(3) STAFF.—

(A) IN GENERAL.—The Secretary shall, after consultation with and consideration of the recommendations of the Board, provide the Board with—

(i) an executive director and 1 other professional staff member, and

(ii) such additional professional staff members including clerical staff, services of consultants, information, and administrative support services (through contracts or other arrangements) as the Secretary deems necessary for the Board to carry out its functions.

(B) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary for the Board to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this section

shall remain available, without fiscal year limitation, until expended.

S 1282 IS——2

S 1282 IS——3

S 1282 IS——4

S 1282 IS——5

S 1282 IS——6